ATTACHMENT 4 Sample ADA 2000 claim form for dental services

Dental Claim Form

©An	nerio	an Der	ntal Assoc	iation, 19	99 version	on 2000														
_			eatment estima		Specialty (se	e backside)	3. Car	rrier Name	9										- 1	
☐ Dentist's statement of actual services 2. ☐ Medicaid Claim Prior Authorization # 4. Carrier Addres									ess											
□EPSDT 1234567							5. City	5. City										6. State 7. Zip		
_	_						<u> </u>													
П	8. P	8. Patient Name (Last, First, Middle) Recipient, Im A.							9. Address				10. City				11. St			
L L	12. Date of Birth (MM/DD/YYYY) 13. Patient ID#							14. Sex				15. Phone Number				16. Zip Code				
PATIENT							5678	67890 □м			:	()								
2	17. Relationship to Subscriber/Employee:											18. Employer/School								
	□Self □Spouse □Child □Other											Name	lameAddress							
	19. Subs./Emp. ID#/SSN# 20. Employer Name							21. Grd	oup#	o #		31. Is Patient covered by another plan				32. Policy #				
											္က	□ No (Skip 32–37) □ Yes: □ Dental or □ Medi				dical	ical			
	22. Subscriber/Employee Name (Last, First, Middle)										OTHER POLICIES	33. Other Subscriber's Name OI-P M-5								
ш	23. Address							24. Phone Number			2	34. Date of Birth (MM/DD/YYYY) 35. Sex				x	x 36. Plan/Program Name			
OYEI							(뮡	/ / DMC			JF						
MP.	25. City 26. State						27. Zip Code			- 1	°۱	37. Employer Name	r/School	Addres		ss.				
SUBSCRIBER / EMPLOYEE							30.				4	38. Subscriber/Employee Status								
	28. Date of Birth (MM/DD/YYYY) 29. Marital Status / / / □Married □Single □						Other		□м			☐Employed ☐Part-time Status ☐Full-time Student				t Part-time Student				
BSG	39. I have been informed of the treatment plan and associated fees. I agree to be res									for all		40. Employer/School								
ซ	charges for dental services and materials not paid by my dental benefit pla dentist or dental practice has a contractual agreement with my plan prohib charges. To the extent permitted under applicable law, I authorize release								nibiting all or a portion of su			Name	authorizo	novment of the	Addres		e navah	le to me o	directly to the	
	charges. To the extent permitted under applicable law, I authorize re to this claim.							arry milom	i i di i i	r Clathrig	19	41. I hereby authorize payment of the dental benefits oth below named dental entity.				3 0 ti 10 ti 10	normise payable to the anestry to the			
	x_								x											
Ш	Sign	ed (Patie	nt/Guardian)			Date	(MM/DD/	(MM/DD/YYYY)				Signed (Emp	Signed (Employee/subscriber)			Date (MM/DD/YYYY)				
	42. Name of Billing Dentist or Dental Entity									hone Ni	umb	44. Provid		44. Provider ID 1234	5678 45. Dentist S		entist Sc	Soc. Sec. or T.I.N.		
		enta Address	l Group)					47. Dentist Licens							49. Plac	e of tre	atment		
TSI			Williams	s St.								series:				■Office □Hosp. □ECF □Other				
BILLING DENTIST	50. City 51. State 52. Zip Code									53. Radiographs or models en								ent for orthodontics? Yes Yoo eady commenced:		
NG	Anytown WI 55555								☐Yes, How many? Date of prior place								1			
BILL	55. If prosthesis (crown, bridge, dentures), is this If no, reason for replacement: initial placement? ☐ Yes ☐ No											remaining								
	56. Is treatment result of occupational illness or injury? ■No ☐ Yes								57. Is treatment result of: □auto accident? □other accident? ☑neither											
	Brief description and dates Brief description											and dates								
58 D	iagno:	is Code I	Index (optional	l)													_			
1			2		3		4		_	5		6	3	7.			8			
_			treatment plan	Surface		nosis Index #	Proc	edure Cod	e (Qty			Descrip	tion		Fee		Adm	in. Use Only	
Date (MM/DD/YYYY) Tooth Surface Diagnosis Index # F								D5110 1			_	Complete	unner	denture		XXX.	ХХ			
				мор	-		2160		1		malgam		uciicaig			XX.XX				
		20 1100									_									
							-													
																			l	
]			
60. Id	entify	all missin	ig teeth with "X						Pri	mar	Total Fee				xxx.xx					
1	Permanent 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A B C D											F G H I J Payment by other plan			XX.XX					
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 T S R Q P													K Ma	x. Allowable						
61. F	Remar	s for unu	sual services										<u> </u>	ductible						
													- ⊢	rrier %						
													Carrier pays Patient pays				-			
								-												
62. I have	62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those												63. Address where treatment was performed							
	dures		\sim	يعلى الدو		654321						⊢	64. City				65.St	ate	66. Zip Code	
X_	od (Tr	ating De		-vw/	License #	UJ4321		(MM/DD/YY		<u>. 1</u> I		ŀ								

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